

Lapse in procedure left thousands of veterans at risk

WASHINGTON - U.S. Rep. Harry Mitchell today called on Department of Veterans Affairs (VA) officials to explain how they plan to restore lost trust following errors in endoscopic procedures that put more than 10,000 veterans at risk of contracting HIV and hepatitis.

"Exposing our veterans to that type of risk is unacceptable, and frankly I'm outraged at the thought of them having to worry about the possibility of being infected," Mitchell said. "The VA now has to work to implement standardized procedures and training to ensure mistakes like these will never happen again. It must work harder and longer to regain the trust of the veterans it serves and care for those who have been exposed."

Mitchell, Chairman of the U.S. House Veterans' Affairs Subcommittee on Oversight and Investigations, chaired today's hearing examining improper reprocessing, incorrect usage, and substandard cleaning of endoscopic equipment at three Department of Veterans Affairs' facilities in Miami, Florida; Murfreesboro, Tennessee; and Augusta, Georgia.

In May, the Department of Veterans Affairs recommended that more than 10,000 former VA patients who received treatment at these three locations get follow-up blood checks. [Source: [The Washington Post](#), May 30, 2009]

To date, 53 of these patients have tested positive for HIV or hepatitis virus B or C. [Source: [U.S. Department of Veterans' Affairs](#), May 27, 2009]

Fewer than half of Veterans Affairs centers given a surprise inspection last month had proper training and guidelines in place for common endoscopic procedures such as colonoscopies - even after the agency learned that mistakes may have exposed thousands of veterans to HIV and other diseases. [Source: [Associated Press](#), June, 15, 2009]

"Most infuriating is the irony that these veterans were undergoing routine medical evaluations to prevent illness, but ultimately, they may be in more danger now than before the procedure," Mitchell added. "Whether illnesses diagnosed after these procedures resulted from the

endoscopies or from unrelated exposures, there is no question that shoddy standards - systemic across the VA - put veterans at risk and dealt a blow to their trust in the VA."